State of California
Department of Health Care Services

APPLICATION TO OBTAIN PROTECTED DHCS DATA FOR PUBLIC HEALTH PURPOSES (FOR COUNTY REQUESTS)

This application is to be used to request access to confidential and protected data held by the Department of Health Care Services (DHCS) for public health purposes. **In addition to this application, requestors must also submit all of the following:**

- A completed Data Description Table
- A copy of filled DUA in word version (see below for detailed instruction)
- A copy of the Committee for the Protection of Human Subjects (CPHS) approval and research protocol

I. Name and contact information for Principal Investigator (PI)

a. Name (Last, First):

b. Title:

c. Public Health Institution:

d. Address:

e. E-mail:

f. Phone #:

g. Fax #:

Name and contact information for other contact person including potential subcontractors (if applicable)

h. Name (Last, First):

i. Title:

j. Public Health Institution:

k. Address:

l. E-mail:

m. Phone #:

n. Fax #:

II. Project Title:

III. Please describe the purpose, goals and objectives of the proposed project. Be sure to describe the background for the project and the potential importance of the findings.

IV. DHCS, under Section 1798.24 (e) of the California Civil Code, can only disclose data with personal information to other governmental agencies where the data "transfer is necessary for the transferee agency to perform its constitutional or statutory duties." Please detail below how the requested data is essential for performing your agency's constitutional or statutory duties.

V. Section 1902 (a) of the federal Social Security Act (42 U.S.C. § 1396a(7)) restricts DHCS from disclosing protected information other than for purposes that are directly connected with the administration of the Medi-Cal Program. Please specify below how the proposed project will benefit the Medi-Cal program.

VI. Current or prior projects completed using DHCS data? ☐ **Yes** ☐ **No**

If **yes**, please provide the following information for the last five projects *(Attach additional sheets if necessary):*

a. Project name:

b. Year completed:

c. DHCS contact person for project and contact person's information

    i. Address:

    ii. Phone #:

    iii. E-mail:

VII. Will the results of the research be published? ☐ **Yes** ☐ **No**

If **yes**, how will it be published? (I.e. journal article, monograph or report, conference presentation, etc.):

Please note that if the project is approved by the DRC that the project title, principal investigator's name and contact information will be posted on the DRC website. Furthermore, if your findings are published in any reports or scientific writings as a result of research using the DHCS data it is expected that you will provide the DRC with the appropriate citation as well as copies of the publications within 30 days. The citations will be posted on the DHCS DRC website.

VIII. Data requests are reviewed by DHCS program staff. If you have contacted DHCS program staff in relation to this project, please provide the following contact information for the individual:

Name:

Telephone number:

E-mail Address:

If not, please check the program area(s) that would be most appropriate to review your request:

☐ Benefits ☐ Care Management/Care Coordination ☐ Children's Medical Services ☐ Claims ☐ Dental ☐ Eligibility

☐ Family Planning ☐ Hospital Financing ☐ Long Term Care ☐ Managed Care ☐ Mental Health Services

☐ Pharmacy ☐ Provider Enrollment ☐ Rural Health ☐ Services Substance Use Disorder (SUD) Services

☐ Other - please explain:

Please visit the DHCS website at www.dhcs.ca.gov for information about each program area

IX. Are you requesting that DHCS data be linked with a non-DHCS database? ☐ **Yes** ☐ **No**

If **Yes**, specify the following:

a. Source:

b. Database Name:

c. Variables to be used for the linkage:

(Please Note: as a policy DHCS does not allow linkages using protected data to be performed by non-DHCS personnel)

X. Methodology. To ensure the data fields being requested will support the analysis you plan to perform, please provide a description of the methodology you will use. In particular, please identify all variables that will be analyzed related to the desired outcomes as well as variables that are used for activities such as stratification and risk adjustment. Please also list any ICD-9-CM, CPT-4, and/or HCPCS codes that are necessary for the data analysis. (Potential codes that may be necessary for your research can be found on the following webpage: http://files.medi-cal.ca.gov/pubsdoco/rates/rateshome.asp). Lastly, indicate the approximate number of records to be analyzed**:**

XI. Subject contact. Are you planning to contact individuals or families as part of this project? **Yes** ☐ **No**

If **Yes**, provide justification and describe methodology of contact:

XII. **Data Use Agreement (DUA)**. Starting in 2018, signatures on DUAs are now collected via DocuSign. Wet ink signatures are no longer required, but still accepted; however, signed and scanned copies are NOT valid for DUA. Please only fill in the grey areas on the word version of the DUA located on the DRC website and do not sign or initial the word version of the DUA if you prefer DocuSign. Once the DRC Application is approved, the individuals listed on the submitted DUA will be contacted by DHCS requesting their electronic signature.

XIII. Funding Sources *(Please specify all sources of funding for the specified project. Attach additional sheets if necessary)*

In general, the DHCS DRC will not support research that will lead to the creation of a product or tool that the researcher or funder intends to market. For example, the DHCS DRC may deny data requests from requestors wanting to evaluate the impact of prescription drugs if a pharmaceutical company finances the study directly or indirectly.

Please check: ☐ County ☐ State Government ☐ Federal Government ☐ Private Funds ☐ Non-Profit ☐ Other

Institution Name:

Address:

Phone #:

Budget *(Please specify how the budget will be utilized)*:

XIV. Desired date for receipt of data. Please specify any financial or other factors influencing this date:

XV. Project timeline:

Application Checklist:

☐ A signed and scanned copy of this application;
☐ A completed Data Description Table in Excel version;
☐ A filled out word version of the Data Use Agreement;
☐ A copy of the Committee for the Protection of Human Subjects (CPHS) approval and research protocol.

Application materials can be submitted electronically to DHCSDRC@dhcs.ca.gov. Signed hard copy of DUA can be mailed to the following address:

Department of Health Care Services
Information Management Division, MS 0021
P.O. Box 997413
Sacramento, CA 95899-7413

Please Note: Prior to the release of any DHCS protected data, a copy of the approval letter by the Committee for the Protection of Human Subjects (CPHS) of the California Health and Human Services (CHHS) Agency must be submitted to the address above. CPHS approval is a separate application process. The CPHS website is www.oshpd.ca.giv/boards/cphs

Signature of Principal Investigator: ______________________

Printed Name (Last, First):

Date:

Signature of the Health Officer or other responsible official for your Agency: ______

Printed Name - (Last, First):

Title:

Agency Name:

Phone #:

E-mail: